FOR OHF USE

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2002
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2002)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0036079

Facility Name: WARREN PARK NURSING PAVILION

Address: 6700 N. DAMEN AVENUE (Number) CHICAGO (City) 60646 (Zip Code)

County: COOK

Telephone Number: (773) 465-5000 **Fax #** (773) 743-5983

IDPA ID Number: 363693973001

Date of Initial License for Current Owners: 03/01/90

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		X	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name:: Steve Lavenda **Telephone Number:** (847) 236 - 1111

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/02 to 12/31/02 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) _____ (Date)
(Type or Print Name) _____
(Title) _____

Paid Preparer
(Signed) See Accountants' Compilation Report Attached (Date)
(Print Name and Title) RICHARD S. SGARLATA, C.P.A.
(Firm Name & Address) Frost, Ruttenberg & Rothblatt, P.C.
111 Pfingsten Road, Suite 300 Deerfield, IL 60015
(Telephone) (847) 236-1111 Fax # (847) 236-1155

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number WARREN PARK NURSING PAVILION # 0036079 Report Period Beginning: 01/01/02 Ending: 12/31/02

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	127	Skilled (SNF)	127	46,355	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	127	TOTALS	127	46,355	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	7,211	2	1,455	8,668	8
9	SNF/PED					9
10	ICF	24,705	544	211	25,460	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	31,916	546	1,666	34,128	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 73.62%

D. How many bed-hold days during this year were paid by Public Aid?
NONE (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
N/A

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 031090

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 3/10/90 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 11 and days of care provided 928

Medicare Intermediary MUTAL OF OMAHA

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/02 Fiscal Year: 12/31/02

* All facilities other than governmental must report on the accrual basis.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number WARREN PARK NURSING PAVILION # 0036079 Report Period Beginning: 01/01/02 Ending: 12/31/02

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	201,036	18,650	6,720	226,406		226,406		226,406			1
2	Food Purchase		185,075		185,075	(42,815)	142,261	(30)	142,231			2
3	Housekeeping	119,764	16,749		136,513		136,513		136,513			3
4	Laundry	41,313	13,316		54,629		54,629		54,629			4
5	Heat and Other Utilities			77,986	77,986		77,986	747	78,733			5
6	Maintenance	45,424	20,023	41,251	106,698		106,698	(924)	105,774			6
7	Other (specify):*							497	497			7
8	TOTAL General Services	407,537	253,813	125,957	787,307	(42,815)	744,493	290	744,783			8
	B. Health Care and Programs											
9	Medical Director			4,200	4,200		4,200		4,200			9
10	Nursing and Medical Records	1,011,665	98,599	8,856	1,119,120		1,119,120	(4,750)	1,114,370			10
10a	Therapy		230	9,229	9,459		9,459	(150)	9,309			10a
11	Activities	89,229	2,967	2,514	94,710		94,710		94,710			11
12	Social Services	70,151		2,985	73,136		73,136		73,136			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	1,171,045	101,796	27,784	1,300,625		1,300,625	(4,900)	1,295,725			16
	C. General Administration											
17	Administrative	107,270			107,270		107,270	158,141	265,411			17
18	Directors Fees											18
19	Professional Services			302,560	302,560	(6,572)	295,988	(266,689)	29,299			19
20	Dues, Fees, Subscriptions & Promotions			28,365	28,365		28,365	(11,112)	17,254			20
21	Clerical & General Office Expenses	93,417	1,118	48,369	142,904		142,904	27,176	170,080			21
22	Employee Benefits & Payroll Taxes			404,783	404,783	42,815	447,598		447,598			22
23	Inservice Training & Education											23
24	Travel and Seminar			2,910	2,910		2,910	199	3,109			24
25	Other Admin. Staff Transportation			1,725	1,725		1,725		1,725			25
26	Insurance-Prop.Liab.Malpractice			115,196	115,196		115,196	204	115,400			26
27	Other (specify):*							20,499	20,499			27
28	TOTAL General Administration	200,687	1,118	903,908	1,105,713	36,243	1,141,956	(71,582)	1,070,374			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,779,269	356,727	1,057,649	3,193,645	(6,572)	3,187,073	(76,191)	3,110,882			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number WARREN PARK NURSING PAVILION #0036079 Report Period Beginning: 01/01/02 Ending: 12/31/02

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			33,465	33,465		33,465	178,996	212,461			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			42,614	42,614		42,614	172,298	214,912			32
33	Real Estate Taxes			126,042	126,042	6,572	132,614	(6,853)	125,761			33
34	Rent-Facility & Grounds			376,671	376,671		376,671	(376,671)	0			34
35	Rent-Equipment & Vehicles			13,136	13,136		13,136	6,354	19,490			35
36	Other (specify):*											36
37	**TOTAL Ownership**			591,928	591,928	6,572	598,500	(25,875)	572,625			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		43,860	39,130	82,990		82,990	(913)	82,077			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			69,533	69,533		69,533		69,533			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		43,860	108,663	152,523		152,523	(913)	151,610			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,779,269	400,587	1,758,240	3,938,096		3,938,096	(102,980)	3,835,116			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number WARREN PARK NURSING PAVILION # 0036079 Report Period Beginning: 01/01/02 Ending: 12/31/02

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	86,613	30		9
10	Interest and Other Investment Income	(36,750)	32		10
11	Discounts, Allowances, Rebates & Refunds	(2,395)	10		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(30)	02		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(6,850)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(2,716)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(26,046)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ 11,827		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(114,806)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (114,806)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (102,980)		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS
WARREN PARK NURSING PAVILION

ID# 0036079
Report Period Beginning: 01/01/02
Ending: 12/31/02

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	1998 R/E tax adjustment	$ (5,745)	33	1
2				2
3	Bank Charge	(7,150)	21	3
4	IL Cope	(2,051)	20	4
5				5
6				6
7				7
8	PPA-Due	(2)	20	8
9	PPA- Office Expense	(34)	21	9
10	PPA-Fees	(35)	21	10
11	PPA-R & M	(1,200)	06	11
12	PPA- Insurance	(2,255)	26	12
13				13
14	Capitalization R & M	(7,149)	06	14
15	Trust fee	(158)	20	15
16	Franchise Tax	(200)	20	16
17	Penalities-Building	(67)	21	17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
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96				96
97				97
98				98
99				99
100				100
101	**Total**	(26,046)		101

STATE OF ILLINOIS

Summary A

Facility Name & ID Number WARREN PARK NURSING PAVILION # 0036079 Report Period Beginning: 01/01/02 Ending: 12/31/02

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary													1
2	Food Purchase	(30)											(30)	2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities			747									747	5
6	Maintenance	(8,349)		2,289	5,136								(924)	6
7	Other (specify):*			60		437							497	7
8	**TOTAL General Services**	(8,379)		3,096	5,136	437							290	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(2,395)						(2,355)					(4,750)	10
10a	Therapy						(150)						(150)	10a
11	Activities													11
12	Social Services													12
13	Nurse Aide Training													13
14	Program Transportation													14
15	Other (specify):*													15
16	**TOTAL Health Care and Programs**	(2,395)					(150)	(2,355)					(4,900)	16
	C. General Administration													
17	Administrative				158,141								158,141	17
18	Directors Fees													18
19	Professional Services			(266,689)									(266,689)	19
20	Fees, Subscriptions & Promotions	(11,977)	358	507									(11,112)	20
21	Clerical & General Office Expenses	(7,287)	67	29,773	4,622								27,176	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar			199									199	24
25	Other Admin. Staff Transportation													25
26	Insurance-Prop.Liab.Malpractice	(2,255)		2,459									204	26
27	Other (specify):*			5,117		15,382							20,499	27
28	**TOTAL General Administration**	(21,518)	425	(228,634)	162,763	15,382							(71,582)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(32,291)	425	(225,538)	167,899	15,819	(150)	(2,355)					(76,191)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number WARREN PARK NURSING PAVILION # 0036079 Report Period Beginning: 01/01/02 Ending: 12/31/02

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	86,613	89,013	3,370									178,996	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(36,750)	206,083	2,965									172,298	32
33	Real Estate Taxes	(5,745)	(3,280)	2,172									(6,853)	33
34	Rent-Facility & Grounds		(376,671)										(376,671)	34
35	Rent-Equipment & Vehicles			6,354									6,354	35
36	Other (specify):*													36
37	TOTAL Ownership	44,118	(84,854)	14,861									(25,875)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers						(589)	(324)					(913)	39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*													43
44	TOTAL Special Cost Centers						(589)	(324)					(913)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	11,827	(84,429)	(210,677)	167,899	15,819	(739)	(2,679)					(102,980)	45

Facility Name & ID Number WARREN PARK NURSING PAVILION # 0036079 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES

A. **Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.**

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
SEE ATTACHED						

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	Rental Income	$ 376,671	WARREN PARK LLC		$	$ (376,671)	1
2	V	33	R/E Tax Over-Accural	121,200	WARREN PARK LLC			(121,200)	2
3	V								3
4	V	32	Interest Expense		WARREN PARK LLC		206,083	206,083	4
5	V	20	Trust Fee		WARREN PARK LLC		158	158	5
6	V	20	Franchise Tax		WARREN PARK LLC		200	200	6
7	V	30	Depreciation		WARREN PARK LLC		89,013	89,013	7
8	V	33	R/E tax expense		WARREN PARK LLC		117,900	117,900	8
9	V	21	Penalities		WARREN PARK LLC		67	67	9
10	V	33	Interest R.T		WARREN PARK LLC		20	20	10
11	V								11
12	V								12
13	V								13
14	Total			$ 497,871			$ 413,441	$ * (84,429)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number WARREN PARK NURSING PAVILION # 0036079 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	5	UTILITIES	$	DYNAMIC HEALTH CARE CONS.	100.00%	$ 747	$ 747	15
16	V	6	REPAIRS & MAINT.				2,289	2,289	16
17	V	7	EMP.BEN. - GEN. SERVICES				60	60	17
18	V	19	PROFESSIONAL FEES				1,518	1,518	18
19	V	20	DUES AND SUBSCRIPTIONS				507	507	19
20	V	21	CLERICAL & GENERAL				29,773	29,773	20
21	V	24	SEMINARS AND TRAVEL				199	199	21
22	V	26	INSURANCE				2,459	2,459	22
23	V	27	EMP.BEN. - GEN. ADMIN.				5,117	5,117	23
24	V	30	DEPRECIATION				3,370	3,370	24
25	V	32	INTEREST				2,965	2,965	25
26	V	33	REAL ESTATE TAXES				2,172	2,172	26
27	V	35	EQUIPMENT RENTAL				6,354	6,354	27
28	V								28
29	V								29
30	V								30
31	V								31
32	V	19	ACCOUNTING FEE	807				(807)	32
33	V								33
34	V	19	BOOKKEEPING FEES	267,400				(267,400)	34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 268,207			$ 57,530	$ * (210,677)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number WARREN PARK NURSING PAVILION # 0036079 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	6	MAINT. CMP. - D. NEHMER	$	DYNAMIC HEALTH CARE CONS.	100.00%	$ 5,136	$ 5,136	15
16	V	10	NURSING CMP - SUE G.						16
17	V	17	ADMIN. CMP. - M. MAUER				28,685	28,685	17
18	V	17	ADMIN. CMP. - M. AARON				42,455	42,455	18
19	V	17	ADMIN. CMP. - F. AARON						19
20	V	17	ADMIN. CMP. - S. GOLDSTEIN						20
21	V	17	ADMIN. CMP. - S. KOPLIN				8,154	8,154	21
22	V	17	ADMIN. CMP. - D. MAGAFAS				9,599	9,599	22
23	V	17	ADMIN. CMP. - E. CASSON						23
24	V	17	ADMIN. CMP. - S. BOGEN				44,449	44,449	24
25	V	17	ADMIN. CMP. - S. LEVY				11,112	11,112	25
26	V	17	ADMIN. CMP. - HOWARD ALTER						26
27	V	17	ADMIN. CMP. - NON-OWNER				13,687	13,687	27
28	V	21	CLERICAL CMP. - S. AARON				4,622	4,622	28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 167,899	$ * 167,899	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number WARREN PARK NURSING PAVILION # 0036079 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	7	EMP. BEN.- D. NEHMER	$	DYNAMIC HEALTH CARE CONS.	100.00%	$ 437	$ 437	15
16	V	15	EMP. BEN.- SUE G.						16
17	V	27	EMP. BEN.- M. MAUER				1,247	1,247	17
18	V	27	EMP. BEN.- M. AARON				1,591	1,591	18
19	V	27	EMP. BEN.- F. AARON						19
20	V	27	EMP. BEN.- S. GOLDSTEIN						20
21	V	27	EMP. BEN.- S. KOPLIN				2,581	2,581	21
22	V	27	EMP. BEN.- D. MAGAFAS				1,331	1,331	22
23	V	27	EMP. BEN.- E. CASSON						23
24	V	27	EMP. BEN.- S. BOGEN				4,119	4,119	24
25	V	27	EMP. BEN.- S. LEVY				1,604	1,604	25
26	V	27	EMP. BEN.- HOWARD ALTER						26
27	V	27	EMP. BEN.- NON-OWNER				2,041	2,041	27
28	V	27	EMP. BEN. - S. AARON				868	868	28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 15,819	$ * 15,819	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number WARREN PARK NURSING PAVILION # 0036079 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	10A	THERAPY	$ 8,346	DYNAMIC REHAB CONSULTANTS, L.L.C.	100.00%	$ 8,196	$ (150)	15
16	V	19	PROFESSIONAL FEES		DYNAMIC REHAB CONSULTANTS, L.L.C.	100.00%			16
17	V	22	EMPLOYEE BENEFITS		DYNAMIC REHAB CONSULTANTS, L.L.C.	100.00%			17
18	V	39	ANCILLARY SERVICES	32,788	DYNAMIC REHAB CONSULTANTS, L.L.C.	100.00%	32,199	(589)	18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 41,134			$ 40,395	$ * (739)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number WARREN PARK NURSING PAVILION # 0036079 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	10	MEDICAL SUPPLIES	16,336	LINCOLN MEDICAL SUPPLIES, INC.	100.00%	13,981	$ (2,355)	15
16	V	39	ANCILLARY EXPENSE	2,250	LINCOLN MEDICAL SUPPLIES, INC.	100.00%	1,926	(324)	16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 18,586			$ 15,907	$ * (2,679)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number WARREN PARK NURSING PAVILION # 0036079 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number WARREN PARK NURSING PAVILION # 0036079 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number WARREN PARK NURSING PAVILION # 0036079 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number WARREN PARK NURSING PAVILION # 0036079 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number WARREN PARK NURSING PAVILION # 0036079 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	MAURY AARON	OWNER	ADMIN	16.69%	SEE ATTACHED	3.48	8.70%	Alloc. Dynamic	$ 42,455	17-7	1
2	MARSHALL MAUER	OWNER	ADMIN	6.30%	SEE ATTACHED	3.16	7.90%	Alloc. Dynamic	28,685	17-7	2
3	SHARON AARON	RELATIVE	CLERICAL		SEE ATTACHED	3.16	7.90%	Alloc. Dynamic	4,622	21-7	3
4	SHEILA BOGEN	OWNER	ADMIN	14.96%	SEE ATTACHED	37	80.00%	Alloc. Dynamic	44,449	17-7	4
5	SHEILA BOGEN	OWNER	ADMIN	14.96%	SEE ATTACHED	37	80.00%	Facility	60,340	17-1	5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 180,551		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number WARREN PARK NURSING PAVILION # 0036079 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: DYNAMIC HEALTHCARE CONSULTANTS
Street Address: 3359 W. MAIN STREET
City / State / Zip Code: SKOKIE,IL 60076
Phone Number: (847) 679-8219
Fax Number: (847) 679-7377

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	UTILITIES	PATIENT DAYS	441,841	13	$ 9,671	$	34,128	$ 747	1
2	6	REPAIRS & MAINT.	PATIENT DAYS	441,841	13	29,639	3,380	34,128	2,289	2
3	7	EMP.BEN. - GEN. SERVICES	PATIENT DAYS	441,841	13	778		34,128	60	3
4	19	PROFESSIONAL FEES	PATIENT DAYS	441,841	13	19,651		34,128	1,518	4
5	20	DUES AND SUBSCRIPTIONS	PATIENT DAYS	441,841	13	6,566		34,128	507	5
6	21	CLERICAL & GENERAL	PATIENT DAYS	441,841	13	385,463	300,175	34,128	29,773	6
7	24	SEMINARS AND TRAVEL	PATIENT DAYS	441,841	13	2,576		34,128	199	7
8	26	INSURANCE	PATIENT DAYS	441,841	13	31,835		34,128	2,459	8
9	27	EMP.BEN. - GEN. ADMIN.	PATIENT DAYS	441,841	13	66,254		34,128	5,117	9
10	30	DEPRECIATION	PATIENT DAYS	441,841	13	43,634		34,128	3,370	10
11	32	INTEREST	PATIENT DAYS	441,841	13	38,384		34,128	2,965	11
12	33	REAL ESTATE TAXES	PATIENT DAYS	441,841	13	28,121		34,128	2,172	12
13	35	EQUIPMENT RENTAL	PATIENT DAYS	441,841	13	82,269		34,128	6,354	13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 744,841	$ 303,555		$ 57,530	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number WARREN PARK NURSING PAVILION # 0036079 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [ ] NO [X]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number WARREN PARK NURSING PAVILION # 0036079 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: DYNAMIC HEALTH CARE CONSULTANTS
Street Address: 3359 W. MAIN STREET
City / State / Zip Code: SKOKIE, IL 60076
Phone Number: (847) 679-8219
Fax Number: (847) 679-7377

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	6	MAINT. CMP. - D. NEHMER	WGHTD. AVG. HOURS	40	10	59,032	59,032	3	5,136	1
2	10	NURSING CMP - SUE G.	WGHTD. AVG. HOURS	40	1	32,744	32,744			2
3	17	ADMIN. CMP. - M. MAUER	WGHTD. AVG. HOURS	40	12	363,103	363,103	3	28,685	3
4	17	ADMIN. CMP. - M. AARON	WGHTD. AVG. HOURS	40	10	487,988	487,988	3	42,455	4
5	17	ADMIN. CMP. - F. AARON	WGHTD. AVG. HOURS	45	6	193,312	193,312			5
6	17	ADMIN. CMP. - S. GOLDSTEIN	WGHTD. AVG. HOURS	37	2	153,497	153,497			6
7	17	ADMIN. CMP. - S. KOPLIN	WGHTD. AVG. HOURS	40	8	71,542	71,542	5	8,154	7
8	17	ADMIN. CMP. - D. MAGAFAS	WGHTD. AVG. HOURS	45	9	87,437	87,437	5	9,599	8
9	17	ADMIN. CMP. - E. CASSON	WGHTD. AVG. HOURS	38	1	31,246	31,246			9
10	17	ADMIN. CMP. - S. BOGEN	WGHTD. AVG. HOURS	45	2	54,060	54,060	37	44,449	10
11	17	ADMIN. CMP. - S. LEVY	WGHTD. AVG. HOURS	45	12	140,632	140,632	4	11,112	11
12	17	ADMIN. CMP. - HOWARD ALT	WGHTD. AVG. HOURS	40	1	12,000	12,000			12
13	17	ADMIN. CMP. - NON-OWNER	WGHTD. AVG. HOURS	45	12	157,563	157,563	4	13,687	13
14	21	CLERICAL CMP. - S. AARON	WGHTD. AVG. HOURS	40	12	58,502	58,502	3	4,622	14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,902,658	$ 1,902,658		$ 167,899	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number WARREN PARK NURSING PAVILION # 0036079 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: DYNAMIC HEALTHCARE CONSULTANTS
Street Address: 3359 W. MAIN STREET
City / State / Zip Code: SKOKIE, IL 60076
Phone Number: (847) 679-8219
Fax Number: (847) 679-7377

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	7	EMP. BEN.- D. NEHMER	WGHTD. AVG. HOURS	40	10	5,020		3	437	1
2	15	EMP. BEN.- SUE G.	WGHTD. AVG. HOURS	40	1	3,128				2
3	27	EMP. BEN.- M. MAUER	WGHTD. AVG. HOURS	40	12	15,782		3	1,247	3
4	27	EMP. BEN.- M. AARON	WGHTD. AVG. HOURS	40	10	18,288		3	1,591	4
5	27	EMP. BEN.- F. AARON	WGHTD. AVG. HOURS	45	6	28,556				5
6	27	EMP. BEN.- S. GOLDSTEIN	WGHTD. AVG. HOURS	37	2	25,672				6
7	27	EMP. BEN.- S. KOPLIN	WGHTD. AVG. HOURS	40	8	22,644		5	2,581	7
8	27	EMP. BEN.- D. MAGAFAS	WGHTD. AVG. HOURS	45	9	12,125		5	1,331	8
9	27	EMP. BEN.- E. CASSON	WGHTD. AVG. HOURS	38	1	3,418				9
10	27	EMP. BEN.- S. BOGEN	WGHTD. AVG. HOURS	45	2	5,010		37	4,119	10
11	27	EMP. BEN.- S. LEVY	WGHTD. AVG. HOURS	45	12	20,299		4	1,604	11
12	27	EMP. BEN.- HOWARD ALTER	WGHTD. AVG. HOURS	40	1	1,296				12
13	27	EMP. BEN.- NON-OWNER	WGHTD. AVG. HOURS	45	12	23,491		4	2,041	13
14	27	EMP. BEN. - S. AARON	WGHTD. AVG. HOURS	40	12	10,982		3	868	14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 195,711	$		$ 15,819	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number WARREN PARK NURSING PAVILION # 0036079 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: DYNAMIC REHAB CONSULTANTS, L.L.C.
Street Address: 3359 W. MAIN STREET
City / State / Zip Code: SKOKIE, IL. 60076
Phone Number: (847) 679-8219
Fax Number: (847) 679-7377

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	10A	THERAPY	DIRECT ALLOCATION						8,196	1
2	19	PROFESSIONAL FEES	DIRECT ALLOCATION							2
3	22	EMPLOYEE BENEFITS	DIRECT ALLOCATION							3
4	39	ANCILLARY SERVICES	DIRECT ALLOCATION						32,199	4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$ 40,395	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number WARREN PARK NURSING PAVILION # 0036079 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: LINCOLN MEDICAL SUPPLIES, INC.
Street Address: 3359 W. MAIN STREET
City / State / Zip Code: SKOKIE, IL. 60076
Phone Number: (847) 679-8219
Fax Number: (847) 679-7377

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	10	MEDICAL SUPPLIES	DIRECT ALLOCATION						13,981	1
2	39	ANCILLARY EXPENSE	DIRECT ALLOCATION						1,926	2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$ 15,907	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number WARREN PARK NURSING PAVILION # 0036079 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number WARREN PARK NURSING PAVILION # 0036079 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number WARREN PARK NURSING PAVILION # 0036079 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number WARREN PARK NURSING PAVILION # 0036079 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number WARREN PARK NURSING PAVILION # 0036079 Report Period Beginning: 01/01/02 Ending: 12/31/02

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1	Devon Bank	X		Mortgage		06/01/95	$	$ 1,981,901			$ 179,899	1
2	MB Financial Bank	X		Note Payable				242,000			40,427	2
3												3
4												4
5												5
	Working Capital											
6	MB Financial Bank			line of credit		09/03/99	700,000	585,000	06/15/03	5.50%	26,184	6
7	Insurance					11/30/22	97,527				2,187	7
8												8
9	TOTAL Facility Related						$ 797,527	$ 2,808,901			$ 248,697	9
	B. Non-Facility Related*											
10	See Supplemental Schedule										(33,785)	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ (33,785)	14
15	TOTALS (line 9+line14)						$ 797,527	$ 2,808,901			$ 214,912	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ 0 Line # _____

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number WARREN PARK NURSING PAVILION # 0036079 Report Period Beginning: 01/01/02 Ending: 12/31/02

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
1	Interest Income	X					$	$			$ (36,750)	1
2	Alloc Dynamic	X									2,965	2
3												3
4												4
5												5
6												6
7												7
8												8
9												9
10												10
11												11
12												12
13												13
14												14
15												15
16												16
17												17
18												18
19												19
20												20
21							$	$			$ (33,785)	21

Facility Name & ID Number WARREN PARK NURSING PAVILION # 0036079 Report Period Beginning: 01/01/02 Ending: 12/31/02

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2001 report.	$	124,000	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	121,934	2
3. Under or (over) accrual (line 2 minus line 1).	$	(2,066)	3
4. Real Estate Tax accrual used for 2002 report. (Detail and explain your calculation of this accrual on the lines below.)	$	127,000	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$	6,572	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ 9,192 For 1998 Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**	$	(5,745)	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	125,761	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
1997	119,803	8
1998	121,156	9
1999	120,343	10
2000	119,923	11
2001	123,042	12

2002 Accrual= 2001 R/E TAX EXPENSE 120,148*1.03=123,752

Alloc from Dynamics $2018

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2001	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2001 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2001 real estate tax costs, as well as copies of your real estate tax bills for calendar 2001.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2001 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2002 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2001 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME WARREN PARK NURSING PAVILION COUNTY COOK

FACILITY IDPH LICENSE NUMBER 0036079

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

TELEPHONE 847-236-1111 FAX #: 847-236-1155

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2001 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2001.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	11-31-302-043	LTC PROPERTY	$ 74,092.96	$ 74,092.96
2.	11-31-302-008	LTC PROPERTY	$ 48,948.89	$ 48,948.89
3.	10-23-404-059-0000	Home Office	$ 26,103.18	$ 2,018.00
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 149,145.03	$ 125,059.85

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? X YES _____ NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2001 tax bills which were listed in Section A to this statement. Be sure to use the 2001 tax bill which is normally paid during 2002.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME WARREN PARK NURSING PAVILION COUNTY COOK

FACILITY IDPH LICENSE NUMBER 0036079

CONTACT PERSON REGARDING THIS REPORT

TELEPHONE ( ) FAX #: ( )

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2000.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.			$	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

Facility Name & ID Number WARREN PARK NURSING PAVILION # 0036079 Report Period Beginning: 01/01/02 Ending: 12/31/02

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 43,400 B. General Construction Type: Exterior BRICK Frame _____ Number of Stories 3

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [X] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

NONE

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____

3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs: _____
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	FACILITY		1985	$ 158,750	1
2					2
3	TOTALS			$ 158,750	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number WARREN PARK NURSING PAVILION # 0036079 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			1990	177,699		20	8,885	8,885	111,571	9
10	Various			1991	40,276		20	2,014	2,014	23,112	10
11	Various			1992	26,271		20	1,314	1,314	14,127	11
12	Various			1993	39,480		20	1,969	1,969	18,158	12
13	Various			1994	61,455		20	3,074	3,074	25,550	13
14	Various			1995	53,672		20	2,685	2,685	20,524	14
15	Various			1996	5,720		20	286	286	1,918	15
16	Various			1997	31,153		20	1,558	1,558	8,808	16
17	Various			1998	142,888		20	7,234	7,234	30,527	17
18								-		-	18
19								-		-	19
20								-		-	20
21								-		-	21
22								-		-	22
23								-		-	23
24								-		-	24
25								-		-	25
26								-		-	26
27								-		-	27
28								-		-	28
29								-		-	29
30								-		-	30
31								-		-	31
32								-		-	32
33								-		-	33
34								-		-	34
35								-		-	35
36								-		-	36

*Total beds on this schedule must agree with page 2.

See Page 12A, Line 70 for total

**Improvement type must be detailed in order for the cost report to be considered complete.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number WARREN PARK NURSING PAVILION # 0036079 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$ -	$	$ -	37
38						-		-	38
39						-		-	39
40						-		-	40
41						-		-	41
42						-		-	42
43						-		-	43
44						-		-	44
45						-		-	45
46						-		-	46
47						-		-	47
48						-		-	48
49						-		-	49
50						-		-	50
51						-		-	51
52						-		-	52
53						-		-	53
54						-		-	54
55						-		-	55
56						-		-	56
57						-		-	57
58						-		-	58
59						-		-	59
60						-		-	60
61						-		-	61
62						-		-	62
63						-		-	63
64						-		-	64
65						-		-	65
66						-		-	66
67						-		-	67
68	Related Party Allocations (Page 12-REP & Page 12A-REP)		2,733,014	70,078		135,917	65,839	1,032,417	68
69	Financial Statement Depreciation			20,236			(20,236)		69
70	TOTAL (lines 4 thru 69)		$ 3,311,628	$ 90,314		$ 164,936	$ 74,622	$ 1,286,712	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number WARREN PARK NURSING PAVILION # 0036079 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 3,311,628	$ 90,314		$ 164,936	$ 74,622	$ 1,286,712	1
2	SPRINKLER SYSTEM	1999	3,912		20	196	196	751	2
3	FIRE ALARM REPAIR	1999	986		20	49	49	188	3
4	SPRINKLER SYSTEM	1999	473		20	24	24	92	4
5	SPRINKLER SYSTEM	1999	941		20	47	47	176	5
6	EMERGENCY DOORS	1999	1,350		20	68	68	244	6
7	NEW DOOR	1999	2,900		20	145	145	520	7
8	FIRE DAMPERS	1999	848		20	42	42	126	8
9	FIRE DAMPERS	1999	2,351		20	118	118	413	9
10	FIRE DAMPERS	1999	2,357		20	118	118	413	10
11	WALK IN COOLER	1999	1,153		20	58	58	174	11
12	ELEVATOR REPAIR	1999	1,095		20	55	55	165	12
13	FIRE ALARM	1999	900		20	45	45	135	13
14	SEWAGE PUMP	1999	511		20	26	26	78	14
15	GLUEDOWN RUNNER	1999	855		20	43	43	129	15
16	EMERGENCY LIGHTS	1999	587		20	29	29	87	16
17	BOILER REPAIR	1999	800		20	40	40	120	17
18	EMERGENCY BATTERY LI	2000	4,800		20	240	240	700	18
19	REFRIGERATOR	2000	2,155		20	108	108	279	19
20	ELEVATOR UPGRADE	2000	2,182		20	109	109	263	20
21	THERAPY	2000	115,660		20	5,783	5,783	14,939	21
22	REMODEL ROOM & HALL	2000	13,178		20	659	659	1,702	22
23	ELEVATOR REPAIR	2000	1,000		20	50	50	117	23
24	PARALLEL BARS	2000	902		20	45	45	98	24
25	REMODELING	2000	12,215		20	611	611	1,324	25
26	BEAUTY SALON DOOR	2000	626		20	31	31	65	26
27	SEWER WORK	2000	2,350		20	118	118	246	27
28	WALLPAPER	2000	1,127		20	56	56	56	28
29	FIRE ALARM REPAIRS	2000	3,353		20	168	168	168	29
30	BATHROOM FIXTURES	2000	561		20	28	28	28	30
31	INSTALLATION OF OUTL	2001	7,175		20	359	359	658	31
32	ELEVATOR REPAIR	2001	1,125		20	56	56	89	32
33	DRAPERIES FOR RESIDE	2001	675		20	34	34	51	33
34	TOTAL (lines 1 thru 33)		$ 3,502,731	$ 90,314		$ 174,494	$ 84,180	$ 1,311,306	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number WARREN PARK NURSING PAVILION # 0036079 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 3,502,731	$ 90,314		$ 174,494	$ 84,180	$ 1,311,306	1
2	TILE	2001	1,139		20	57	57	90	2
3	WIRING ON AC UNIT	2001	15,110		20	1,511	1,511	1,763	3
4	CABINETS	2001	10,150		20	1,015	1,015	1,184	4
5	ROOF REPAIRS	2001	3,909		20	391	391	456	5
6	WALLPAPER	2001	532		20	27	27	27	6
7	SPRINKLER SYSTEM	2001	923		20	46	46	46	7
8	FIRE ALARM REPAIRS	2001	709		20	35	35	35	8
9	ELECTRICAL WORK	2001	625		20	31	31	31	9
10	FIRE ALARM REPAIRS	2001	533		20	27	27	27	10
11	KITCHEN VENTILATOR	2001	752		20	38	38	38	11
12	FIRE PUMP REPAIRS	2001	1,215		20	61	61	61	12
13	TELEPHONE SYSTEM	2002	10,122		20	169	169	169	13
14	SEWER PIPE	2002	3,100		20	310	310	310	14
15	CHIMENY RECONSTRUCT	2002	1,350		20	34	34	34	15
16	ELECTRICAL OUTLET INSTALLATION	2002	1,800		20	15	15	15	16
17	REMOVAL OF TREES	2002	1,800		20	90	90	90	17
18	GLASS INSTALLATION	2002	1,161		20	106	106	106	18
19	INSTALL EMERGENCY LIGHTS	2002	1,149		20	48	48	48	19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,558,810	$ 90,314		$ 178,505	$ 88,191	$ 1,315,836	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number WARREN PARK NURSING PAVILION # 0036079 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		$ 3,558,810	$ 90,314		$ 178,505	$ 88,191	$ 1,315,836	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,558,810	$ 90,314		$ 178,505	$ 88,191	$ 1,315,836	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number WARREN PARK NURSING PAVILION # 0036079 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		$ 3,558,810	$ 90,314		$ 178,505	$ 88,191	$ 1,315,836	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
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26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,558,810	$ 90,314		$ 178,505	$ 88,191	$ 1,315,836	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number WARREN PARK NURSING PAVILION # 0036079 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12E, Carried Forward		$ 3,558,810	$ 90,314		$ 178,505	$ 88,191	$ 1,315,836	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,558,810	$ 90,314		$ 178,505	$ 88,191	$ 1,315,836	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number WARREN PARK NURSING PAVILION # 0036079 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12F, Carried Forward		$ 3,558,810	$ 90,314		$ 178,505	$ 88,191	$ 1,315,836	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
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27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,558,810	$ 90,314		$ 178,505	$ 88,191	$ 1,315,836	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number WARREN PARK NURSING PAVILION # 0036079 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12G, Carried Forward		$ 3,558,810	$ 90,314		$ 178,505	$ 88,191	$ 1,315,836	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,558,810	$ 90,314		$ 178,505	$ 88,191	$ 1,315,836	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number WARREN PARK NURSING PAVILION # 0036079 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12H, Carried Forward		$ 3,558,810	$ 90,314		$ 178,505	$ 88,191	$ 1,315,836	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,558,810	$ 90,314		$ 178,505	$ 88,191	$ 1,315,836	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number WARREN PARK NURSING PAVILION # 0036079 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12I, Carried Forward		$ 3,558,810	$ 90,314		$ 178,505	$ 88,191	$ 1,315,836	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,558,810	$ 90,314		$ 178,505	$ 88,191	$ 1,315,836	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number WARREN PARK NURSING PAVILION # 0036079 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12I, Carried Forward		$ 3,558,810	$ 90,314		$ 178,505	$ 88,191	$ 1,315,836	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,558,810	$ 90,314		$ 178,505	$ 88,191	$ 1,315,836	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number WARREN PARK NURSING PAVILION # 0036079 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	127		1995		$ 2,698,750	$ 69,199	35	$ 134,938	$ 65,739	$ 1,023,280	4
5			1993		34,264	879	35	979	100	9,137	5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
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25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A-REP, Line 70 for total

Facility Name & ID Number WARREN PARK NURSING PAVILION # 0036079 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 2,733,014	$ 70,078		$ 135,917	$ 65,839	$ 1,032,417	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number WARREN PARK NURSING PAVILION # 0036079 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 128,345	$ 1,265	$ 12,380	$ 11,115	10	$ 75,933	71
72	Current Year Purchases	29,585	13,132	1,762	(11,370)	10	1,762	72
73	Fully Depreciated Assets	412,622	19,814	19,814		10	412,621	73
74								74
75	TOTALS	$ 570,552	$ 34,211	$ 33,956	$ (255)		$ 490,316	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Facility	DODGE - MIDWAY	1993	$ 21,583	$ 1,323	$	$ (1,323)	5	$ 21,583	76
77	Alloc Dynamic									77
78										78
79										79
80	TOTALS			$ 21,583	$ 1,323	$	$ (1,323)		$ 21,583	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$	4,309,695	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$	125,848	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$	212,461	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$	86,613	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$	1,827,735	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number WARREN PARK NURSING PAVILION # 0036079 Report Period Beginning: 01/01/02 Ending: 12/31/02

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2003	$
13.	/2004	$
14.	/2005	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO

16. Rental Amount for movable equipment: $ 5,136 Description: Cooler $39 dishwasher $720, IceMaker$1802, Copier $2575,
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	FACILITY	LEXUS	$ 619.89	$ 8,001	17
18	Dynamic alloc			6,354	18
19					19
20					20
21	TOTAL		$ 619.89	$ 14,355	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number WARREN PARK NURSING PAVILION # 0036079 Report Period Beginning: 01/01/02 Ending: 12/31/02

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

			1	2	3	4
			Facility			
			Drop-outs	Completed	Contract	Total
1	Community College Tuition		$	$	$	$
2	Books and Supplies					
3	Classroom Wages	(a)				
4	Clinical Wages	(b)				
5	In-House Trainer Wages	(c)				
6	Transportation					
7	Contractual Payments					
8	Nurse Aide Competency Tests					
9	TOTALS		$	$	$	$
10	SUM OF line 9, col. 1 and 2	(e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

SEE ACCOUNTANTS' COMPILATION REPORT

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39 - 03	hrs	$		$ 18,141	$		$ 18,141	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			160			160	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			20,325			20,325	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39 - 03	# of prescrpts			504	24,790		25,294	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): See Supplemental						19,070		19,070	13
14	TOTAL			$		$ 39,130	$ 43,860		$ 82,990	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number WARREN PARK NURSING PAVILION # 0036079 Report Period Beginning: 01/01/02 Ending: 12/31/02

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/02 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 527	$ 18,220	1
2	Cash-Patient Deposits	78,159	78,159	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	577,656	587,656	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	39,267	39,267	6
7	Other Prepaid Expenses	1,075	1,075	7
8	Accounts Receivable (owners or related parties)	587,675	669,284	8
9	Other(specify): See Supplemental Schedule	38,218	74,595	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,322,577	$ 1,468,256	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		158,750	13
14	Buildings, at Historical Cost		2,698,750	14
15	Leasehold Improvements, at Historical Cost	765,431	1,082,931	15
16	Equipment, at Historical Cost	259,057	259,057	16
17	Accumulated Depreciation (book methods)	(372,682)	(1,212,057)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	7,000	7,000	19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(7,000)	(7,000)	20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):		(216,344)	22
23	Other(specify): See Supplemental Schedule	216,439	216,439	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 868,245	$ 2,987,526	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,190,822	$ 4,455,782	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 231,970	$ 231,978	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	78,159	78,159	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	138,344	138,344	30
31	Accrued Taxes Payable (excluding real estate taxes)	2,207	2,207	31
32	Accrued Real Estate Taxes(Sch.IX-B)	127,000	127,000	32
33	Accrued Interest Payable	1,906	145,422	33
34	Deferred Compensation			34
35	Federal and State Income Taxes	3,738	3,738	35
	Other Current Liabilities(specify):			
36	See Supplemental Schedule			36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 583,324	$ 726,848	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	827,000	2,808,901	39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See Supplemental Schedule			43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 827,000	$ 2,808,901	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,410,324	$ 3,535,749	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 780,498	$ 920,033	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,190,822	$ 4,455,782	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

Facility Name & ID Number WARREN PARK NURSING PAVILION # 0036079 Report Period Beginning: 01/01/02 Ending: 12/31/02

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 975,425	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 975,425	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(135,872)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(59,055)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (194,927)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 780,498	24 *

*** This must agree with page 17, line 47.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number WARREN PARK NURSING PAVILION # 0036079 Report Period Beginning: 01/01/02 Ending: 12/31/02

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 3,732,260	1
2	Discounts and Allowances for all Levels	(156,686)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 3,575,574	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	102,750	6
7	Oxygen	2,203	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 104,953	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	34,801	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	3,304	19
20	Radiology and X-Ray	180	20
21	Other Medical Services	28,440	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 66,725	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	36,750	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 36,750	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	18,222	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 18,222	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 3,802,224	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	787,307	31
32	Health Care	1,300,625	32
33	General Administration	1,105,713	33
	B. Capital Expense		
34	Ownership	591,928	34
	C. Ancillary Expense		
35	Special Cost Centers	82,990	35
36	Provider Participation Fee	69,533	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 3,938,096	40
41	**Income before Income Taxes (line 30 minus line 40)****	(135,872)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (135,872)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return?** Cash Basis **If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.** SEE ACCOUNTANTS' COMPILATION REPORT

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number WARREN PARK NURSING PAVILION # 0036079 Report Period Beginning: 01/01/02 Ending: 12/31/02

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,229	2,468	$ 61,976	$ 25.11	1
2	Assistant Director of Nursing	1,967	2,131	46,008	21.59	2
3	Registered Nurses	17,523	19,079	353,525	18.53	3
4	Licensed Practical Nurses	4,483	4,812	80,260	16.68	4
5	Nurse Aides & Orderlies	51,379	56,157	466,600	8.31	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	2,006	2,086	39,050	18.72	9
10	Activity Assistants	6,593	6,860	50,179	7.32	10
11	Social Service Workers	4,522	4,883	70,151	14.37	11
12	Dietician					12
13	Food Service Supervisor	1,983	2,166	36,234	16.73	13
14	Head Cook	6,189	6,890	67,963	9.86	14
15	Cook Helpers/Assistants	11,927	13,043	96,839	7.42	15
16	Dishwashers					16
17	Maintenance Workers	2,235	2,402	45,424	18.91	17
18	Housekeepers	14,102	15,376	119,764	7.79	18
19	Laundry	5,154	5,637	41,313	7.33	19
20	Administrator	2,086	2,166	60,340	27.86	20
21	Assistant Administrator	2,113	2,297	46,930	20.43	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	9,661	10,442	93,417	8.95	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	280	280	3,296	11.79	31
32	Other Health Care(specify)					32
33	Other(specify) See Supplemental					33
34	TOTAL (lines 1 - 33)	146,430	159,174	$ 1,779,269 *	$ 11.18	34

SEE ACCOUNTANTS' COMPILATION REPORT

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	226	$ 6,720	01-03	35
36	Medical Director	84	4,200	09-03	36
37	Medical Records Consultant	80	3,440	10-03	37
38	Nurse Consultant	50	1,616	10-03	38
39	Pharmacist Consultant	85	3,400	10-03	39
40	Physical Therapy Consultant	79	4,320	10a-03	40
41	Occupational Therapy Consultant	81	4,367	10a-03	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	12	542	10a-03	43
44	Activity Consultant	60	2,514	11-03	44
45	Social Service Consultant	55	2,985	12-03	45
46	Other(specify)				46
47	DENTAL CONSULTANT		400	10-03	47
48					48
49	TOTAL (lines 35 - 48)	810	$ 34,504		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number WARREN PARK NURSING PAVILION # 0036079 Report Period Beginning: 01/01/02 Ending: 12/31/02

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Sheila Bogen	Administrator		$ 60,340
Jocelyn Ledesma	Assistant Admin		46,930
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 107,270

B. Administrative - Other

Description	Amount
	$
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$

C. Professional Services

Vendor/Payee	Type	Amount
Health Data System	Data Processing	$ 3,932
Sachnoff & Weaver	Legal	6,176
Dynamic HealthCare	Bookkeeping	267,400
Finkel, Martwick & Colson	Legal	6,573
FR & R	Accounting	14,305
Dynamic HealthCare	Accounting	807
Econocare	Purchase Consulant	2,286
Personnel Planner	Unemployment Consulant	1,080
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $2500 attach copy of invoices.)		$ 302,558

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 48,752
Unemployment Compensation Insurance	10,388
FICA Taxes	134,863
Employee Health Insurance	195,605
Employee Meals	42,815
Illinois Municipal Retirement Fund (IMRF)*	
Chicago head -tax	4,152
Employee Benefits	11,023
TOTAL (agree to Schedule V, line 22, col.8)	$ 447,598

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	7,965
Health Care Worker Background Check	
(Indicate # of checks performed)	1,612
Due & Subcriptions	5,038
Licenses and Permits	2,132
Alloc Dynamic	507
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 17,254

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	
Seminar	2,910
Alloc Dynamic	199
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 3,109

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number WARREN PARK NURSING PAVILION # 0036079 Report Period Beginning: 01/01/02 Ending: 12/31/02

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number WARREN PARK NURSING PAVILION # 0036079 Report Period Beginning: 01/01/02 Ending: 12/31/02

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **Yes**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **IL Council $7089**

(3) Did the nursing home make political contributions or payments to a political action organization? **YES** If YES, have these costs been properly adjusted out of the cost report? **YES**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? _____ If YES, what is the capacity? _____

(5) Have you properly capitalized all major repairs and equipment purchases? **YES**
What was the average life used for new equipment added during this period? **10YRS**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **6,856** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **YES** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **NO**
If YES, give effective date of lease. _____

(9) Are you presently operating under a sublease agreement? _____ YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

_____

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **69,533**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **NO** If YES, attach an explanation of the allocation.

SEE ACCOUNTANTS' COMPILATION REPORT

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **N/A**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **NO** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **42,815** Has any meal income been offset against related costs? **NO** Indicate the amount. $ _____

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **NO**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **NO** If YES, please indicate the amount of income earned from such a program during this reporting period. $ _____
c. What percent of all travel expense relates to transportation of nurses and patients? **100 IN 14**
d. Have vehicle usage logs been maintained? **YES**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **NO**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? _____
Firm Name: **N/A** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? _____ If no, please explain. _____

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? **YES**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **YES**
Attach invoices and a summary of services for all architect and appraisal fees